The impact of rhetoric and reality on community anticipation of risk in the development of multi-purpose services: A grounded theory study.

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Abstract:

Title:

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Aims:

The rhetoric of multi-purpose services involves the integration of aged care facilities and other health services (usually hospitals) in small, rural communities while enhancing responsiveness to community needs. This research focussed on the main concerns of participants involved in the development of multi-purpose services in rural NSW.

Method:

Using a constructivist grounded theory methodology 30 in-depth interviews were conducted with 6 community members, 10 managers and 14 staff members who had been involved in the process of developing multi-purpose services.

Findings:

The findings presented in this paper reflect the reality of the community members' participation in the development of multi-purpose services as perceived by all groups of participants. The main concern (core category) of all participants which emerged was their *anticipation of risk.* This *anticipation of risk* manifested itself in either trust or fear and explained their progression through a three phased social process: *driving change, engaging with stakeholders* and *collaborating*. The initial phase (*driving change*) focussed on whether or not forces initiating the change process were external to or within the local community, with local drivers engendering more trust than external ones. When local community members were actively involved in this phase they had a greater influence in the next phase (*engaging with stakeholders*). *Engaging with stakeholders* involved town meetings, forming committees and consulting communities. When community stakeholders felt that this was a superficial process they feared the consequences of decisions. In the third phase, *collaborating,* influential community members (who had been involved) were again more likely to trust in the multi-purpose service model and to embrace an integrated health service identity. Those stakeholders who felt their involvement had only been superficial were more likely to maintain that the previous hospital services provided a better health service.

Conclusion:

This research provides an insight into the perceptions of the rhetoric and reality of community member involvement in the process of developing multi-purpose services. It revealed a grounded theory in which fear and trust were intrinsic to a process of changing from a traditional hospital service to the acceptance of a new model of health care provided at a multi-purpose service.

Introduction

The Multi-purpose Service Program began in 1991 as a solution to health problems being experienced in rural Australia. These problems included poor health outcomes in comparison with their metropolitan counterparts, difficulty attracting staff and a lack of viability and range of health services in rural areas. Large variations in rural population numbers created major differences in their needs and ability to sustain health services within individual communities (1-3).

Community consultation is viewed by the Australian government as extremely important in both the development and ongoing management of multi-purpose services (4, 5). Despite this positive attitude to consumer consultation, Humphreys et al. (6) felt that when consultation occurred it often served to empower the service provider rather than the community. Similarly, in their case study of the development of a multi-purpose service in Victoria, Hoodless and Keating (7) found that the health care organisation was unable to engage the community effectively. They recommended a process of devolving authority to the community, but found health service providers and the boards of management unable or unwilling to utilise this process. The over-representation of these health service providers and managers resulted in a fragmented and delayed redevelopment process which created conflict and confusion among stakeholders and the community. This literature indicates that the reality of community participation in multi-purpose service development is more superficial than the rhetoric of government policy would suggest.

The aim of this study was to develop an understanding of the process involved in the development of multi-purpose services in rural New South Wales from the perspectives of stakeholders. This paper, which is abstracted from that larger study aims to discuss aspects of this process which were related to community members.

Method

Grounded theory is a general method of generating theoretical frameworks to uncover the meanings and interpretations which participants hold, rather than imposing a framework upon them. This makes it useful for research where little is known about a social process (8-11). Development of a theory specific to the Australian context where multi-purpose services are being developed will take into account rural issues not apparent in other contexts. Grounded theory methodology commonly begins with a broad question (12). The theory which was developed using this approach was ‘grounded’ due to the constant comparison which takes place between developing theory and data relating directly to the real-life experiences of participants (13).

In this research, a constructivist perspective on grounded theory was taken. Constructivism takes a relativist stance, where differing viewpoints of participants were equally accepted as their reality. No participant was viewed as being more important or factual than another. The constructivist paradigm was selected as it took into account the researcher’s subjectivity, and included a belief that different groups of people would experience reality differently within their context and interpersonal relations (14, 15).

Data Collection

Following ethics approval, a total of thirty participants were interviewed (6 community members, 10 managers and 14 staff members) who were connected to 13 multi-purpose services spread across western New South Wales. The multi-purpose service sites in the study were all small rural communities as the multi-purpose service concept was primarily designed

for small communities of up to 4,000 people. All multi-purpose services had been commissioned for 2-7 years, and participants were interviewed about their experiences of the development of a multi-purpose service.

Initial data collection involved a purposive sample of three participants each with a unique role in the development of a multi-purpose service. These included a staff member, a manager and a community member. The data collected from these in-depth interviews led to the development of categories and the identification of other participants to be interviewed; a process called theoretical sampling (10, 13). Data analysis and data collection then proceeded concurrently in accordance with grounded theory research methods.

Data Analysis

Data was collected over a twelve month period. Initially open coding was undertaken with an 'open' frame of mind – without any prior assumptions about what may exist in the data (8). This involved a line by line analysis of each interview which resulted in a large number of codes, with initial labels reflecting the reality for the participants. As data collection and analysis progressed, codes which were conceptually related were grouped forming categories. These categories were labelled to identify concepts in the developing theory, but were often revised, as more data was collected or further analysis took place. Constant comparison led to the initial categories, which were relatively simple and descriptive, becoming conceptualised, and inclusive of more data.

As the clarity of categories improved, relationships between categories emerged from the data, through a process known as theoretical coding (8). These categories were *driving change, engaging with stakeholders* and *collaborating*. After this process was complete, a core category emerged (*Anticipating risk*). Categories were seen to be theoretically saturated when new data did not reveal any new categories, and at this point data collection ceased.

Findings

The findings presented in this paper reflect the key factors expressed by all groups of participants in the development of multi-purpose services related to community member participation. The main concern (core category) of all participants which emerged from the data was their *Anticipation of risk*. The social process of developing a multi-purpose service was revealed to have three phases: *driving change, engaging with stakeholders* and *collaborating.*

Driving change

Becoming a multi-purpose service involved changing the model of care being utilised in small rural hospitals. According to participants, this change could be driven by locals such as community members or people external to the community such as government departments. *Trust* was more likely to develop among community members when this process was driven by local stakeholders. When the decision to develop the multi-purpose service was made external to the local community, they had a greater *fear* of the outcome. Two important components which participants viewed as driving the change were economic issues and recognising the need for services.

The participants were aware of economic issues associated with capital funding that was required to improve the physical infrastructure of health services within their communities. They described these services as being run down. For example:

it's a hospital that's got the roof falling in and termites eating around the doors, and the doors falling off (Kate).

The condition of existing health service buildings made it obvious to participants that additional funding was required for the local health service and that it would be unwise to refuse an offer of a large amount of money. Community members in particular were aware of the impact which funding could have by providing employment in their community. No participant was able to identify another option for attracting funding. As one community member stated:

we knew that we really didn't have a choice (Christine).

This placed the community in a situation where they had little power to negotiate. Several participants mentioned feeling they were being *"blackmailed"*. They had little choice but to be grateful for what they were offered.

Recognition of the need for further funding for their health services, led some communities to embrace the multi-purpose service concept. One manager described a local council which drove the initial planning phase, advertising for and selecting steering committee members without a great deal of input from the health service. Another community member described a town meeting organised by the local hostel board, where a committee was selected to lobby for such a project. In these cases local control was felt to be maintained in this initial phase and led to greater trust of other stakeholders in the following phase. The community members working on these committees felt that they had taken the initiative and lobbied to attract the funding that their community required. The feeling that they were driving the change in the health service made them more trusting of those people external to their community who could help them to achieve their goals.

In this study, participants reported that the health service always maintained a dominant role in any merger which took place. Small service providers (e.g. aged care, home care) with independent funding were reduced or *"given up"* to the health service along with any funding they relied upon. This resulted in a centralisation of decision makers which made them less accessible by community members. One community member said:

It used to be that you could drive half an hour to [neighbouring city] and talk to them. Now it's two hours to [distant city]. It's out of sight, out of mind. Now you have to phone, fax or send an email and by the time you arrange to see someone, its next week or more (Jeff).

Several communities not only recognised the need for additional health services but had been sufficiently active in the past to instigate such services themselves. For many communities the need for aged care services was predicted for several years prior to the suggestion of a multi-purpose service. In these cases, the communities raised capital funding for the infrastructure required and obtained ongoing aged care funding for the services they then provided. The tactics which they had learnt from these successes were ones which they continued to employ during the process of developing the multi-purpose service. In this context, a community member felt:

it was like everything else, if you don't ask, you don't get it … I was the chairperson on the hostel board for years, so I had a better idea of grants, plus I was there and I was the instigator of getting another five beds (George).

These communities clearly had a history of local success which was frequently undermined by government claims that their facilities were not viable entities and should be subsumed by the new multi-purpose service development. Such communities felt that their needs were being dictated by external drivers of change and were more hesitant to trust other stakeholders involved in the process of developing multi-purpose services.

When local community members drove this initial phase they took with them a sense of achievement and trust. They felt that their opinions would be valued in the following phase of engagement. When this phase had been driven by people external to the local community, the community often feared that their needs may not be met and their opinions not sought.

Engaging with stakeholders

The phase of *engaging with stakeholders* for community members included interactions with government bodies, other communities, managers and staff members. Factors involved in this phase included being part of a rural community and working as a committee. Community members reported feeling engaged when they perceived that they had some influence in the process of developing multi-purpose services.

Living in the same rural community created a bond between community members, managers and staff. Living in a small community was important to community members who felt the need to trust each other, in a way they did not think was understood by people living in larger communities. The isolation, which was common at most sites in this study, created a degree of self-reliance within these communities. Community members discussed the close-knit nature of their towns. Their feelings of being part of a rural community were so strong they projected these feelings onto others, assuming that people living in similar communities had similar feelings to themselves. As one community member remarked:

where you come from, was it a small community? … If anything happens, if you have a major catastrophe in the community … You know everyone will support that person, family, whatever the situation (George).

Multi-purpose services in other communities were often visited by community members and managers. When this occurred, community members were often given advice on how to manage their interactions with government agencies. This interaction with other communities had a positive aspect of building trust and cohesion between them, allowing support and the exchange of information between communities of similar size. It also had a negative aspect as people from larger communities were distrusted merely due to the size of the community they came from.

Health service managers in particular felt pressure to be engaged with the local community in order to be accepted in their role as manager of the multi-purpose service. The issue of where the manager lived was recognised as being important by the community members and staff members, but not by people outside the community. The following observation was made by one manager:

[Manager] didn't have good community back up or staff back up, probably because she's not a local (Tracey).

The health service acknowledged the need for community participation in the development of the multi-purpose service. Frequently this resulted in the formation of community committees to advise the health service. Although some committees were influential, others were more easily controlled by the health service. When community members perceived themselves as having been influential in this phase they were more likely to trust other stakeholders and encourage collaboration with them.

Collaborating

The phase of *Collaborating* involved the combination of various health services as one identity. For community members this involved acknowledging the new identity. The new model of care had been the subject of community meetings organised by Commonwealth and State Government Departments at the beginning of the process. Despite this many participants had only focussed on the physical aspects, the new building. On numerous occasions community members referred to the new health service as a hospital. In the final stage of the process of developing the service, when a name change was to occur, it became an issue. It was at this point that some of the initial fears of community stakeholders became more apparent, for example:

it doesn't really describe what it is. People felt that they were losing their hospital … we're gazetted as [community] MPS. Now that says nothing about a hospital, and once again that perception that they are losing a hospital really worries people (Jane).

Further confusion was created when some local government councils created multi-purpose centres which contained a mixture of council services. One manager described this confusion in the following manner:

what the local council did was they set up Multi-purpose Centres to be one-stop shops, where you can pay your bills, and go to the library and this, that and the other, and unfortunately that concept got confused with the MPS concept (Jane).

Some community members, who did not embrace the new multi-purpose service, were more likely to cling to their old terminology. They portrayed themselves as having faced a threat to their hospital which had been defeated. The rhetoric they engaged in described little change for their community (e.g. *"only the name changed"* or *"only the building changed").*

Some communities continued to be empowered, not conceding to demands that the original name of their hospital be altered. As one manager stated:

that was decided by the Steering Committee and the Health Council, so they feel good that that was adopted. We haven't even got MPS anywhere in our title (Tracey).

As time passed the concept of a multi-purpose service became more acceptable to some communities; the novelty faded and more multi-purpose services were developed in other towns. A manager described how this occurred in her community:

I heard someone down the street the other day refer to it as the MPS … he didn't call it the [community] Nursing home or the old hospital … So maybe it is filtering through to your little community, who'll filter it on probably to other communities (Ruth).

Discussion

Trust, altruism and reciprocity are necessary to build social capital (16, 17), and although these factors were described by participants in this study, social capital did not emerge as a major category. The main issue for community members was related to *Anticipation of risk* and the trust and fear which they felt as a result of this anticipation. The model of trust developed by Mayer et al., (18) involves three factors of perceived trustworthiness: ability, benevolence and integrity. Such an assessment of risk includes consideration of context which weighs the likelihood of positive or negative consequences of action (18, 19). These factors which impacted on the ability to generate and maintain trust were clearly demonstrated in this study. They were experienced by all participants as they went through the process of developing a multi-purpose service.

In the phase of *driving change,* community members assigned greater trust to local drivers of change rather than those drivers external to the community. In order to produce positive outcomes Woolcock (17) and Brown (20) described the need for both top down (external) and bottom up (local) drivers of change, which were dynamic and cooperative. They indicated a need to nurture the social ties between local community members at the micro level and civil society and institutions at the macro level. For those communities in this study which lobbied for the development of a multi-purpose service at an early stage, this established the value and strategic importance of their role as the development progressed.

Current health and government policy encourages the involvement of community members in the development of multi-purpose services. The phase of *engaging with stakeholders* described this involvement. Focusing on those stakeholders with sufficient power to influence the organisation may be more efficient, but the complexity of stakeholder interaction made this difficult. By developing strategies to guide an organisation's behaviour towards stakeholders, the assumption is made that they can be 'managed'. One aim of seeking local community input is to assist in generating community support for policy change (21) but as Jonker and Foster (22) point out many stakeholder groups are quite sophisticated and aware that organisations attempt to manipulate them. In this study, the findings revealed that community committee members routinely assessed the degree of influence they had on the development of the multi-purpose service and when they considered themselves to have been influential this enabled them to trust other stakeholders leading to a greater level of collaboration in the final phase

In the final phase of the process of developing a multi-purpose service, the different degrees of collaboration emerged as an important finding. The core category, *Anticipation of risk,* determined the degree collaboration which took place. Cooperation did not entail as much risk as integration, demonstrating lower levels of trust between organisations (23). This study found that many community members continued to differentiate the services which were now functioning on one site, perceiving them to be cooperating rather than integrating them into a single model of health care. Participants were, however continuing to reframe their perspectives of their health service, casting the new multi-purpose service model in a more positive light, as they compared their results with those of other communities.

Conclusion

The process of developing a multi-purpose service occurred in three phases with community members an integral stakeholder in each phase. The impact of rhetoric and reality were central to the ability of community members to risk accepting this new model of care in their rural communities. Trust in decision makers by community members was more likely when the multi-purpose service development was driven by local stakeholders, when community members perceived themselves as influential in the process and when services within the new model of care were seen to be working as a single integrated health service.

Acknowledgements

CSUPRS Scholarship

References

1. Sach J. Multi-purpose Services Program Evaluation (Victoria): Final Report. Melbourne; 2000.
2. National Rural Health Alliance, Aged and Community Services Australia. Older people and aged care in rural, regional and remote Australia. Canberra; 2004.
3. Hoodless M, Evans F. The Multipurpose service program: the best health service option for rural Australia. Australian Journal of Primary Health. 2001;7(1):90-6.
4. Australian Government Department of Health and Ageing. National quality improvement framework for Multipurpose Services. 2004.
5. Commonwealth Department of Health & Ageing. Multipurpose Services: Meeting your health and aged care needs. Office of Rural Health; n.d.
6. Humphreys J, Hegney D, Lipscombe J, Gregory G, Chater B. Whither rural health? Reviewing a decade of progress in rural health. Australian Journal of Rural Health. 2002;10(1):2-14.
7. Hoodless M, Keating T. Community processes associated with a changing rural health service. 5th Wonca World Conference on Rural Health; 2002 30 April - 3 May; Melbourne, Australia. 2002.
8. Glaser BG. Basics of grounded theory analysis. Mill Valley, California: Sociology Press; 1992.
9. Charmaz K. Constructing grounded theory: a practical guide through qualitative analysis. California: Sage Publications; 2006.
10. Glaser BG, Strauss AL. The discovery of grounded theory: strategies for qualitative research. New York: Aldine De Gruyter; 1967.
11. Strauss AL, Corbin JM. Basics of qualitative research: techniques and procedures for developing grounded theory. 2nd ed. Thousand Oaks: Sage Publications; 1998.
12. Corbin JM, Strauss AL. Basics of qualitative research: techniques and procedures for developing grounded theory. 3rd ed. Thousand Oaks, California: Sage Publications; 2008.
13. Glaser BG. Theoretical sensitivity. Mill Valley, California: The Sociology Press; 1978.
14. Patton MQ. Qualitative research & evaluation methods. 3rd ed. Thousand Oaks, California: Sage Publications; 2002.
15. Charmaz K. Grounded theory: Objectivist and constructivist methods. In: Denzin NK, Lincoln YS, editors. Handbook of qualitative research. 2nd ed. Thousand Oaks, California: Sage Publications; 2000. p. 509-37.
16. Portes A. Social Capital: Its Origins and Applications in Modern Sociology. Annual Review of Sociology. 1998;24(1):1.
17. Woolcock M. Social capital and economic development: Toward a theoretical synthesis and policy framework. Theory & Society. 1998;27(2):151-208.
18. Mayer RC, Davis JH, Schoorman FD. An Integrative Model of Organizational Trust. Academy of Management Review. 1995;20(3):709-34.
19. Gefen D, Rao VS, Tractinsky N. The Conceptualization of Trust, Risk and Their Relationship in Electronic Commerce: The Need for Clarifications. 36th Annual Hawaii International Conference on System Sciences; 2003 6-9 January. 2003.
20. Brown VA. Leonardo's Vision: A Guide to Collective Thinking and Action. Sense Publishers; 2008.
21. Fraser EDG, Dougill AJ, Mabee WE, Reed M, McAlpine P. Bottom up and top down: Analysis of participatory processes for sustainability indicator identification as a pathway to community empowerment and sustainable environmental management. Journal of Environmental Management. 2006;78(2):114-27.

22. Jonker J, Foster D. Stakeholder excellence? Framing the evolution and complexity of a stakeholder perspective of the firm. Corporate Social Responsibility and Environmental Management. 2002;9(4):187-95.
23. Brown K, Keast R. Citizen-Government engagement: Community connection through networked arrangements. Asian Journal of Public Administration. 2003;25(1):107-31.